Ambience

Unlocking revenue cycle efficiencies across care settings

A buyer's guide to evaluating specialty-specific AI scribing and point-of-care CDI technology

Primary Care

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Enhancing revenue cycle efficiency is essential in today's healthcare landscape, especially as documentation and coding complexities continue to increase.

AI scribing and clinical documentation improvement (CDI) solutions offer an effective approach to optimizing revenue cycle management at the point-of-care, providing solutions across primary care, emergency departments, and inpatient settings.

This buyer's guide explores how these solutions can transform revenue cycle operations across multiple specialties by ensuring compliance, maximizing reimbursement, and enhancing clinician efficiency.

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Ambulatory setting

Realizing documentation & E/M accuracy through specialty-specific AI in ambulatory care settings

Ambulatory care is complex and varied, demanding that AI scribing and point-of-care solutions be attuned to the unique needs of each specialty within the outpatient setting.

From primary care to cardiology and psychiatry in the examples that follow, each specialty requires unique coding and documentation practices to capture the full scope of patient care accurately. The examples also emphasize the importance of specialty tuning and coding awareness for effective point-of-care solutions.

Primary care

Primary care clinicians often struggle to keep up with the complexity of Evaluation and Management (E/M) coding guidelines, which frequently change and can be challenging to navigate. This difficulty can lead many providers to rely on time-based coding rather than capturing the full complexity of the care they deliver. In ambulatory settings, E/M levels are the most common denial by the Office of Inspector General (OIG) and RAC auditors, and the AAPC estimated that clinicians lose 5-10% of revenue by consistently undercoding.

As such, time-based coding often falls short in accurately reflecting patient needs and the level of care provided. AI-powered scribing and coding solutions should address this by recommending optimal E/M CPT codes in real-time based on the interpreted clinical complexity. Tools with Modifier 25 prompts can further enhance billing by capturing both preventive and sick care services during preventive visits. Integrated directly within the workflow, these tools offer coding suggestions and provide an audit trail, supporting precise billing, simplifying appeals, and helping to reduce instances of over-coding and under-coding to increase compliance.

> **E/M levels are the most common denial by the Office of Inspector General (OIG) and RAC auditors**

5-10%

Lost revenue by consistently undercoding, according to the AAPC

Additionally, with the growth of risk-based contracts, such as Medicare Advantage, accurate HCC-mapped ICD-10 coding has become essential to ensure that funding aligns with the cost of patient care. Given the labor-intensive nature of HCC documentation, primary care clinicians often spend extra hours weekly updating records to stay compliant. AI solutions should streamline this process by suggesting specific ICD-10 codes and prompting clinicians for additional details when needed, producing MEAT-compliant documentation that supports optimal reimbursement.

Primary care CDI highlights

E/M Coding Optimization:

- Solutions should recommend optimal E/M CPT codes based on clinical complexity, reducing both over-coding and under-coding.
- This accuracy helps minimize revenue loss, audit risks, and improves compliance with current E/M coding guidelines.

Improved HCC Capture for Risk-Based Contracts:

- Supports clinicians in accurately capturing HCC-mapped ICD-10 codes essential for Medicare and other risk-based contracts; critical for reducing risk of denials.
- Ensures MEAT-compliant documentation to meet reimbursement requirements, reducing funding shortfalls.

Modifier 25 Utilization:

- Prompts for Modifier 25 during annual wellness visits (AWVs) when additional sick care services are provided.
- Enhances revenue capture by documenting and billing for both preventive and sick care in one visit.

Primary care evaluation questions

E/M Coding Efficiency

- How does the solution identify and recommend the most appropriate CPT codes for complex patient care in primary care settings?
- Does it provide real-time prompts or suggestions directly within the clinician workflow?

Compliance and Audit Risk Reduction:

- Is the solution "coding aware," ensuring documentation supports billed ICD-10 and service codes?
- What mechanisms are in place to reduce instances of over-coding and under-coding?
- How does the solution support audit trails for claims appeals and compliance reviews?

HCC Capture and Risk-Based Contracts:

- How does the solution ensure accurate capture of HCC-mapped ICD-10 codes and maintain MEAT compliance?
- Can the system adapt to periodic HCC mapping changes, such as V24 to V28, and alert clinicians accordingly?

Modifier 25 and AWVs:

- How does the solution recognize and prompt for Modifier 25 during AWVs when sick care is provided?
- Does it effectively distinguish between preventive and sick care within a single visit to ensure correct billing?

Cardiology

Cardiologists face a substantial administrative burden, dedicating an average of 16 hours per week to documentation and related tasks, according to the 2023 Medscape Physician Compensation Report. This significant time investment limits their capacity to see more patients, impacting both productivity and revenue generation. The growing complexity of cardiovascular cases further amplifies documentation needs, as accurate record-keeping is essential for proper coding and reimbursement.

AI scribing and point-of-care CDI solutions help alleviate these challenges by streamlining the documentation process. These solutions should support the documentation of medical necessity in cardiology, thereby reducing denials. By surfacing these codes during follow-up appointments, these tools make it easy for clinicians to apply them, capturing additional revenue opportunities that might otherwise be overlooked.

Moreover, AI scribing solutions can accelerate chart closures and streamline billing cycles. Slow chart completion can lead to high DNFB, impacting cash flow and increasing financial strain. AI scribing tools should allow for faster chart closures, accelerating billing and reducing the cycle time. This efficiency not only improves cash flow but may also make practices eligible for bonuses tied to timely chart completion, where such incentives apply.

In addition, enhanced CDI capabilities within these tools ensure the specificity of ICD-10 coding for cardiac conditions, minimizing the use of "unspecified" codes that can trigger denials or reduce reimbursements. With accurate point-of-care documentation, the need for coding clarifications decreases, which can significantly reduce the query rate and the potential for appeals. This documentation accuracy helps secure appropriate reimbursement and expedites the appeals process for any denials that do occur.

Finally, advanced AI scribing tools support the documentation of underutilized smoking cessation counseling codes, such as 99406 and 99407, and nudging the provider when they have completed this service. This improved capture of smoking cessation services not only generates additional revenue but also supports patient outcomes by encouraging quit attempts. Meeting quality metrics in areas like smoking cessation can also earn practices value-based care bonuses from payers, providing further financial incentives.

By enhancing productivity, reducing administrative overhead, and maximizing revenue capture, AI scribing and point-of-care CDI solutions should help cardiology practices thrive financially while maintaining a high standard of patient care.

✓ Cardiology CDI highlights

Utilization of Complex Care Codes:

- Enhanced coding support facilitates the use of add-on codes like G2211 for complex or chronic patient cases, capturing more complete revenue for long-term care.

Improved Chart Closure Rate:

- Faster chart closures decrease billing cycle time, accelerating cash flow and supporting compliance with potential chart-completion bonus programs.

Accurate ICD-10 Coding:

- Documentation that supports medical necessity of diagnostics, procedures, and medications, including documentation around "step therapy" requirements.
- Specificity in ICD-10 coding for cardiac conditions helps prevent claim denials and reduces dependency on "unspecified" codes, enhancing reimbursement accuracy.

Support for Smoking Cessation Counseling:

- Streamlined documentation processes make it easier to apply smoking cessation codes (99406 and 99407), driving additional revenue and improving patient outcomes.
- Meeting smoking cessation quality metrics can increase value-based care bonuses from payers.

? Cardiology evaluation questions

Coding for Complex Cases:

- How does the solution support coding for complex or chronic care patients, such as with add-on codes like G2211?
- Are these add-on codes surfaced automatically during follow-ups to ensure accurate coding?

Chart Closure and Billing Cycle:

- Does the solution facilitate same-day chart closures to improve the billing cycle?
- What mechanisms are in place to support practices with chart-completion bonuses or other time-based incentives?

CD-10 Specificity and Compliance:

- How does the solution ensure specificity in ICD-10 coding for cardiac conditions, reducing the use of "unspecified" codes?

Smoking Cessation Counseling Documentation:

- How does the solution support the documentation of smoking cessation counseling services to ensure accurate use of codes 99406 and 99407?
- Does it provide guidance on meeting quality metrics that may qualify the practice for additional bonuses?

Psychiatry

Psychiatrists face a considerable administrative burden when it comes to documenting patient encounters, often spending between 30 and 60 minutes per session on charting. This documentation workload limits the number of patients they can see, reducing their overall capacity and impacting revenue potential. AI scribing and point-of-care CDI tools can significantly alleviate this burden by streamlining the charting process. By reducing documentation time per patient, psychiatrists can complete charts more efficiently, freeing up time that can be redirected toward patient care. With time savings of 10-15 minutes per patient, providers can potentially add two more patient visits per day, which cumulatively contributes to an increase in patient volume and revenue.

For psychiatrists who handle follow-up sessions, the 90833 psychotherapy add-on code often remains underutilized due to documentation time constraints and the additional steps involved in billing it alongside E/M codes. However, with the right AI scribing solution, the documentation and billing of 90833 become more straightforward, as the code is surfaced automatically in follow-up sessions, reminding clinicians to apply it when appropriate. This ease of use can increase utilization of the 90833 code, capturing additional revenue without adding to the documentation workload.

AI scribing tools should also support improved chart closure rates, allowing psychiatrists to complete documentation within the same day. Many psychiatrists currently face delays of three days or more to finalize patient charts, impacting the billing cycle and cash flow. A streamlined documentation process enables same-day chart closures, which not only accelerates billing but also enhances cash flow, an essential benefit for practices aiming to maintain financial health and timely reimbursement.

Accurate ICD-10 coding is another significant advantage provided by these solutions. In psychiatry and all other medical specialties, relying on "unspecified" codes for diagnoses, particularly for Medicaid and Medicare patients, often leads to denials or reduced reimbursements. AI-powered documentation solutions help ensure precise and specific coding, decreasing the risk of denials and minimizing the need for coder clarification. With improved ICD-10 coding, practices can secure more reliable reimbursement, maintain compliance, and reduce administrative burdens tied to appeals and queries.

✅ Psychiatry CDI highlights

Time Savings in Documentation:

- AI scribing solutions reduce the time spent on charting per patient, freeing up additional time for patient care.
- Time saved allows for the potential to see additional patients per day, increasing overall patient volume and revenue.

Utilization of 90833 Add-On Code:

- AI-generated documentation makes it easier to apply the 90833 psychotherapy add-on code during follow-up sessions.
- Increased utilization of this add-on enhances revenue capture for services provided alongside E/M codes.

Improved Chart Closure Rates:

- Faster chart closure lowers the time from visit to billing, which speeds up the billing cycle and accelerates cash flow.

Accurate ICD-10 Coding:

- Enhanced specificity in ICD-10 coding minimizes the use of "unspecified" codes, reducing claim denials and ensuring appropriate reimbursement.
- Accurate, specific coding supports compliance with Medicaid/Medicare standards and reduces coding queries.

❓ Psychiatry evaluation questions

Documentation Efficiency:

- How much time does the solution save per patient on documentation, and what is the impact on clinician capacity?

Utilization of Add-On Codes (e.g., 90833):

- How does the solution support the appropriate use of the 90833 psychotherapy add-on code during follow-up sessions?
- Does the system automatically prompt or surface the 90833 code during applicable sessions to optimize coding?

Chart Closure and Billing Cycle:

- Does the solution enable same-day chart closures to improve the billing cycle and accelerate cash flow?
- Are there features in place to help meet chart-completion targets for potential compliance bonuses?

ICD-10 Coding Accuracy:

- How does the solution support specificity in ICD-10 coding to reduce the reliance on "unspecified" codes?

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Emergency setting

Enhancing critical care documentation, capturing procedure information, and optimizing E/M coding accuracy in emergency care settings

Emergency Departments (EDs) are under immense pressure to provide high-quality patient care while also maintaining operational efficiency and financial stability.

When evaluating AI-powered medical scribing and coding solutions, understanding their potential impact on critical areas such as documentation, coding accuracy, and procedure capture is essential.

Emergency setting

One of the key challenges in ED documentation is the accurate and complete billing of critical care services. Critical care billing codes (99291 & 99292) are often underutilized due to incomplete documentation, leading to missed revenue opportunities. Clinicians may overlook vital components, such as specific diagnoses, procedures, or time spent on critical interventions. AI scribing solutions can address this by providing real-time prompts and nudges, helping clinicians capture the necessary documentation for critical care billing. This not only enhances revenue by ensuring all services are documented but also improves compliance and accurately reflects the complexity of patient care provided in emergency settings.

Another significant area of improvement with AI-powered tools is Evaluation and Management (E/M) coding accuracy. In the fast-paced environment of the ED, critical E/M coding components such as independent interpretations, differential diagnoses, and consultations are often under-documented, leading to coding inaccuracies. These inaccuracies can result in both over-coding, which increases audit risk, and under-coding, which results in lost revenue. The right AI scribing tools offer real-time feedback on documentation elements needed to support accurate coding levels, ensuring all necessary

> " Traditionally, emergency department directors or CDI teams audit charts to identify potential critical care opportunities, a labor-intensive and often imperfect process. By listening to the entire encounter, a coding-aware AI scribe can prompt clinicians to consider coding for critical care.

Stephani Scott
RHIT, CPC, AAPC, from AAPC white paper, _AI Scribe Guide: Why Coding-Aware AI Scribes Are Essential_

information is captured. This not only reduces query rates and compliance risks but also helps optimize revenue by billing at the appropriate level based on patient acuity.

In addition to critical care and E/M coding, many EDs miss revenue opportunities from quick, routine procedures that often go undocumented, such as splint applications

Emergency setting

or wound repairs. AI-powered scribing solutions can automatically identify when these procedures are performed, prompting clinicians to document them thoroughly. Comprehensive procedure notes enhance billing accuracy, increase revenue integrity, and reduce the likelihood of compliance issues stemming from incomplete documentation.

Ultimately, AI-powered medical scribing and coding solutions offer EDs an invaluable resource for improving financial outcomes and operational efficiency. By streamlining documentation, ensuring coding accuracy, and capturing all billable services, these solutions allow ED clinicians to focus more on patient care while optimizing the ED's financial health and compliance. This buyer's guide is designed to help healthcare leaders identify solutions that empower key performance drivers in ED RCM, ensuring that documentation and billing practices fully support the department's goals.

Emergency medicine CDI highlights

Critical Care Documentation:

- AI-powered solutions improve capture of critical care codes (99291 & 99292) by prompting clinicians to document essential components, enhancing revenue and compliance.

- Real-time prompts support clinicians in documenting time spent, procedures, and specific diagnoses needed for accurate critical care billing.

Optimized E/M Coding Accuracy:

- Enhanced documentation ensures all elements are captured for higher-level E/M codes (99284 & 99285), reducing risks of over-coding or under-coding.

- Real-time feedback on missing documentation elements helps support intended billing levels and reduces compliance risks.

Procedure Documentation:

- Routine but commonly under-documented procedures, such as splint applications or wound repairs, are automatically identified and prompted for documentation.

- Improved capture of these procedures increases revenue and reduces compliance risk.

Emergency medicine evaluation questions

Critical Care Documentation:

- How does the solution support the documentation of critical care codes (99291 & 99292) in real time?

- Does the tool provide prompts or alerts to ensure that critical care services are documented thoroughly for billing compliance?

E/M Coding Accuracy:

- What specific E/M coding components (e.g., independent interpretations, consultations) does the solution capture to ensure accurate billing levels?

- Does it provide real-time feedback on missing documentation elements to support higher-level codes accurately?

Procedure Documentation:

- How does the solution identify and prompt for documentation of routine ED procedures, such as splint applications or wound repairs?

- Can it improve procedure documentation capture rates?

Compliance and Audit Risk:

- How does the solution reduce over-coding or under-coding risks to enhance compliance?

- What audit-support features are available, such as documentation trails or real-time compliance checks?

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Inpatient setting

Improving clinical documentation accuracy and CDI Staff resource utilization in inpatient settings

In the inpatient setting, precise clinical documentation and ICD-10 coding accuracy are essential for revenue optimization and compliance. Many hospitals face challenges with incomplete coding that leads to missed opportunities for capturing complications and major comorbidities (CC/MCC), which can result in lower Diagnosis-Related Group (DRG) values and increased denial rates.

Inpatient setting

A common revenue cycle issue in inpatient settings is the delay caused by Discharged Not Final Billed (DNFB), where incomplete documentation prevents timely claim submission. AI-driven scribing tools can help reduce DNFB by enabling more efficient charting at the point of care, minimizing the need for post-visit documentation queries. Automated prompts may ensure all necessary information is captured, reducing the query rate by up to 30%. This streamlines the billing process, allowing for faster claim submission, accelerating cash flow, and reducing operational inefficiencies associated with prolonged DNFB periods.

Quicker claim submission and a shortened payment cycle are critical in managing hospital cash flow. AI-powered documentation solutions may facilitate real-time capture of clinical information, reducing the lag between service delivery and billing submission. By accelerating the billing process, hospitals can reduce days to payment by as much as 20-30%, thereby enhancing liquidity and operational efficiency.

Length of Stay (LOS) is another key performance metric impacting operational costs and patient throughput in the inpatient setting. Accurate documentation supports optimized DRG assignments, which in turn helps care teams project a reliable geometric length of stay (GMLOS) and coordinate timely

> "Lack of appropriate support for supporting ICD-10 codes may result in failure to qualify for potential CC/MCC that would map to a higher value DRG.

Stephani Scott
RHIT, CPC, AAPC, from AAPC white paper, _AI Scribe Guide: Why Coding-Aware AI Scribes Are Essential_

discharges. A reduction in LOS, even by a fraction of a day, translates to significant cost savings for hospitals, reducing the financial strain of avoidable days.

Another important benefit is improved resource utilization, especially within CDI teams, who consistently seek more resources to enhance their impact. CDI teams can focus their efforts on more complex cases, improving the quality of documentation where it has the highest impact on reimbursement. This allows CDI specialists to contribute more strategically, reducing query rates for simpler cases. Additionally, AI solutions can mitigate burnout among CDI staff by streamlining workflows and reducing repetitive documentation tasks.

✓ Inpatient CDI highlights

Enhanced ICD-10 Coding | and CC/MCC Capture:

- AI solutions improve coding specificity and capture more accurate complication and comorbidity (CC/MCC) codes.
- Increased CC/MCC capture raises DRG values, maximizing reimbursement and reducing denial rates.

Reduction in DNFB (Days Not Final Billed):

- Streamlined documentation processes at the point of care reduce DNFB, accelerating the billing cycle and improving cash flow.
- Automated documentation prompts reduce query rates by up to 30%, minimizing delays in claim submissions.

Optimized Length of Stay (LOS):

- Improved documentation accuracy supports optimized DRG assignments, allowing care teams to project reliable GLOS for timely patient discharges.

- Even small reductions in LOS lead to significant cost savings and improved patient throughput.

Faster Claim Submission and Payment Cycles:

- Real-time documentation at the point of care reduces the lag between care delivery and billing, shortening days to payment by 20-30%.
- Improved cash flow and liquidity support overall hospital financial health.

Efficient CDI Resource Utilization:

- Routine documentation is automated, allowing CDI teams to prioritize complex cases.
- Reduced query rates and improved workflows help prevent CDI staff burnout, reducing turnover and associated costs.

? Inpatient evaluation questions

ICD-10 Coding Accuracy and CC/MCC Capture:

- How does the solution ensure specific and accurate ICD-10 coding to improve CC/MCC capture rates?

Reducing DNFB (Days Not Final Billed):

- Does the solution facilitate point-of-care documentation to reduce DNFB days?

Length of Stay (LOS) Optimization:

- How does the solution support accurate DRG assignment to project and manage GLOS?
- Can it help reduce LOS, and what are the estimated cost savings from improved discharge coordination?

Conclusion

In today's rapidly evolving healthcare landscape, precision in clinical documentation and coding is no longer just an operational necessity but a strategic advantage.

Specialty-specific AI scribing and CDI solutions enable healthcare organizations to optimize their revenue cycle management. They can achieve significant gains in compliance, reimbursement, and clinician efficiency. The best of these tools are tailored to adtdress the unique needs across various care settings and specialties, enhancing the quality and accuracy of documentation at the point of care.

By integrating specialty-specific AI solutions, healthcare providers can reduce administrative burdens, allowing clinicians to focus on patient care without compromising documentation quality.

Such solutions improve coding accuracy, reduce the risk of denials, and support healthcare organizations in meeting value-based care targets, ultimately strengthening their financial health and operational resilience.

As healthcare organizations seek sustainable documentation improvements, adopting AI scribing and CDI solutions that meet the specific demands of each specialty and care setting is critical. This guide empowers decision-makers with the insights to select a solution that aligns with their goals, transforming documentation practices and maximizing value across all patient interactions.

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